STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 10,734
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the Department of Social Welfare's refusal to grant her waivered Medicaid coverage of her home nursing expenses from October 1, 1990 to August 3, 1991 due to her alleged failure to cooperate in providing verification of her resources.

FINDINGS OF FACT

1. The petitioner is an elderly woman who lives alone and has had a series of health care problems in the last few years beginning with a broken hip in 1988. At that time, she asked her next door neighbor of fifteen years (an employed man with small children) to become her guardian so that she could remain in the home she has lived in for sixty-five years. He agreed and the probate Court approved him as her guardian in September of 1989.

2. In January of 1990, the petitioner applied for Medicaid coverage but was denied due to the existence of a trust fund account which contained over $11,000.00 worth of stock. Following that denial the guardian cashed in the stocks, put them in the petitioner's checking and savings accounts and used the money to pay the petitioner's medical

and living expenses for the next few months.

3. In June of 1990, the petitioner suffered a stroke for which she was hospitalized until September of 1990. She had partial Medicare coverage but no private insurance to pay the remainder of the hospital bill. In order to return home, which she wished to do, her doctor told her that she needed some kind of home health care which she could not afford. The petitioner was advised by her health providers to apply for Medicaid coverage.

4. The petitioner's guardian took time off work and went to the D.S.W. office to apply for Medicaid in June of 1990 while she was still hospitalized. The guardian was later notified that for the Department to find the petitioner eligible, he would have to show that the petitioner no longer had the money in the trust fund. After receiving that notice, the guardian called to report that the trust fund had been expended as of February 5, 1990, but was unable to speak with anyone and was told that his phone call would be returned. It never was. The guardian made an appointment to speak with the Medicaid specialist on September 1, 1990. However, when the guardian arrived for the appointment he was told that the worker was unable to meet with him. Another worker copied the ledgers and receipts which the guardian brought in on that day, including a statement from the petitioner's trust company indicating that all the stock in the trust account, which

then totaled $8,966.73, had been sold as of February 5, 1990 and that the trust account had a total share balance of "000".

5. On September 7, 1990, the petitioner was found eligible for S.S.I. by the Social Security Administration retroactive to July 1, 1990. Because of that determination, the petitioner became automatically eligible for Medicaid and no further action was taken by the worker with regard to determining her general Medicaid eligibility based on her state application.

6. On September 20, 1990, the guardian applied to the Medicaid division for a "waiver" which would allow the Department to cover nursing services needed by the petitioner to stay at home rather than move to a nursing home where coverage of such services is routinely provided. Eligibility for the waiver through the Medicaid Division required that D.S.W. make a determination of her financial eligibility for long term care even though she was already known to be Medicaid eligible as an S.S.I. recipient.

7. The Department is limited by the Health Care Financing Administration (H.C.F.A.) to granting waivered services to a limited number of persons based on the availability of nursing home beds in the state. The Department usually maintains a waiting list for waivered services. Prior to September 29, 1990, the Department had 150 of these "slots" and a considerable waiting list. On September 29, 1990, the Medicaid Division got 100 extra

slots from the H.C.F.A. Approximately 50 of those slots remained after persons on the existing waiting list were assisted. By the beginning of 1991, those slots were filled and a new waiting list was begun.

8. After reviewing the documents brought in by the guardian in September, the D.S.W. specialist felt he was still unable to make a determination on resource eligibility necessary to granting the home-based waiver. The guardian was asked by letter to come to the office "one more time to help us figure out the verification you brought in". If he did not do so, he was warned that the petitioner "will be responsible for paying for her care".

9. The guardian took time off work again to meet with the worker on November 29, 1990. At that time, they went over the ledger and the worker was satisfied that the $8,966.73 from the stocks cashed in in February had been spent on the petitioner's living and medical expenses and was totally accounted for. Although the worker had the account summary from the trust dated February 5, 1990 which showed the sale of all the shares in the trust and the "000" balance, the worker stated that he needed a letter showing that the account had "closed". The guardian suggested they call the broker from the office to confirm the "closure" of the account. They spoke to the broker by phone who said the February 5, 1991 statement was self explanatory that "000" in the balance column meant nothing is left in the account although the account itself was "still active", that is, it

had not been officially closed. The worker responded that the account had to be closed and that the broker's oral assurance that it would be was not sufficient. He told the broker that he needed a letter saying the account was closed. The stockbroker said he would provide such a statement.

10. No confirmation of the account's "closure" arrived, however, and the petitioner's application languished for lack of that document. The guardian himself requested that it be sent three or four times with no result.

11. In the meantime, the petitioner who was back home with no way to pay for her medical care got a $60,000.00 line of credit on her house to pay for her personal and medical care which cost approximately $1,100.00 per week. All of her credit line has been exhausted paying for these expenses.

12. Simultaneously, the Medicaid Division, in possession of extra slots and anxious to decide the petitioner's eligibility for a waiver, repeatedly asked D.S.W. for a determination on the petitioner's long term care financial eligibility and was repeatedly told that her guardian was not cooperating in providing information. After a final discussion with D.S.W., the Medicaid waiver division notified the petitioner on March 27, 1991 that she was ineligible for waivered services because "information requested by D.S.W. district office has not been submitted,

therefore, ineligible for Long Term Medicaid".

13. The guardian does not recall ever receiving the notice of denial of the waiver dated March 27, 1991, among the many papers he receives on behalf of his ward. However, concerned about the delay in processing the petitioner's claim for current services, the guardian called the waiver services division directly on April 2, 1991. During the conversation he was told that he had a right to a fair hearing but the guardian still did not realize that the services had actually been denied. He did not file for a hearing because he felt he wanted to keep working with the intake specialist and believed everyone was trying to resolve the matter. There is no evidence that the guardian was told or understood that the expenditures she made while her application was pending would not be reimbursed when her eligibility was ultimately determined.

14. Sometime in June of 1991, the petitioner received a letter dated June 21, from her trust fund confirming that "all of your Putnam Fund accounts are closed. We are not maintaining any open accounts under tax paper I.D. number [___] or in your name". The letter referred to one account number, the same one which appeared on the statement dated February 5, 1990. This letter was forwarded to the Department which received it July 15, 1991. After submission of this document the guardian was asked to and did fill out a new application on July 31, 1991.

15. At about the same time, the guardian contacted

legal aid and other advocates for the aged who wrote letters to the Department on the petitioner's behalf. The concern in these letters was not only for the delay in the home health care financing but also the lack of a decision on retroactive Medicaid coverage for the month of June 1990 which was not covered by the S.S.I. decision in July. The hospital also called to request this coverage.

16. After reviewing these letters and the new trust documentation, the D.S.W. worker contacted the Medicaid division in late August to confirm the petitioner's financial eligibility back to the original date of application. The Medicaid division decided therefore to retract its original denial of March 27, 1991 and to find that the petitioner was eligible for services based on her September 20, 1990 application. However, she was notified that payments in that program could only be made prospectively from the date the determination of eligibility was made. Because a "slot" became available in early August, the petitioner began receiving services on August 4, 1991. The Department refused to make a retroactive reimbursement for the petitioner's home health costs.

17. On August 12, 1991 the petitioner was notified by the D.S.W. worker that her general Medicaid eligibility would be made retroactive to June 1, 1990, the month of her original application.

18. On September 9, 1991, the petitioner appealed the Department's decision not to reimburse her home health care

expenses from October 1, 1990 to August 3, 1991.

ORDER

The Department's decision is reversed and it is ordered that the petitioner be reimbursed for services covered by the waiver program from October 1, 1990 to August 4, 1991.

REASONS

Waivered home health care services is an option which may be provided through the Medicaid program to assist persons who "but for the provision of home or community based services" would require a level of care requiring institutionalization in a hospital or nursing home which would have been covered by Medicaid payments. See 42 U.S.C. ə 1396n(c), 45 C.F.R. ə 435.217. Vermont participates in this waivered coverage program which is inversely linked to the number of nursing home beds which do not need to be developed because of this service. The program is referred to in the Department's Medicaid regulations at two places, first as a categorical basis for eligibility at M ə 200(8), and second, with reference to countable income and resources for participants who receive mental health services through the program at M ə 223. There have been no other regulations promulgated by the Department regarding this program. In taking actions in this area, the Department relies on various policy and procedure manuals which it has developed but which have not been thoroughly updated to reflect current practice.

The petitioner argues in this matter that her eligibility for waivered home health care services, once determined, should have been made retroactive to her initial date of eligibility. Her essential argument is that waivered services are no different from other services covered under Medicaid which are, by regulation, covered from the initial date of application. M ə 121 The Department relying on its unpromulgated policies, argues that waivered services are covered prospectively only once eligibility is determined and once a "slot" becomes available. The limited availability of this service, for which there is usually a greater demand than supply, makes it impossible, in the Department's view, to make this service retroactive to the date of application when there has been a delay in verifying eligibility. The Department adds in support of its position, that there are currently several persons who have been determined eligible for Medicaid and for the needed services who will not be eligible to receive the home health care waiver until other "slots" become available. The petitioner does not dispute the limited availability of the "slots".

Although the parties have framed the issue in terms of the "retroactivity" of waivered service coverage eligibility, the facts in this case make it unnecessary to reach that question. That is because the facts show that the petitioner presented ample verification of her financial condition even before she actually applied for services on

September 20, 1990.

The Department's general Medicaid regulations require the verification of "all resources, when the total is within $200.00 of the resource maximum . . ." M ə 126. That same regulation defines verification as "proof of an applicant's statements by written records or documents shown to a Department employee, or by statements of another person who adds to or supports the applicant's statements." M ə 126 In addition, the Department's Procedures Manual indicates that where the amount in a bank account is in question, a verification form should be sent by the Department to the bank with a postage prepaid envelope. See P - 2421B.

In September of 1990, the petitioner's guardian made an appointment and came in to the Department's office with an official trust account statement clearly showing that her stocks had been cashed in February of 1990 and that her account balance was zero. Her guardian also brought records showing exactly how those resources were spent. If someone had been there to speak with him, any questions the Department may have had should have easily been cleared up at that time. The petitioner should not have been penalized for the Department's inability to find someone to analyze the information at that time. In addition, the Department was aware in September that the petitioner had been found eligible for the federal S.S.I. program, another means tested program with similar relatively low resource limits. That S.S.I. eligibility alone should have alerted the

Department to the petitioner's probable eligibility for long term care.

In addition, at the November meeting, the worker received a statement via telephone from the petitioner's broker confirming that no funds were in the account. Under the regulations, even that kind of oral verification is sufficient and in this case represented cumulative evidence of what already existed in writing. If after receiving all this information the worker still did not understand that there was no money in the account, the Department's own policies strongly indicate that he, not the applicant was expected to send a pre-printed verification form to the trust officer in a prepaid envelope and that it was not the petitioner's obligation to hound the trust officer or stockbroker for the additional verification. The worker in this case handled this matter under the apparent belief that a trust account had to be "closed" in order to verify resource eligibility. That belief misses the essential point of financial eligibility which has always been to determine what income or resources are actually available to the petitioner to use for her living and medical expenses. W.A.M. ə 2260, Fair Hearing No. 8501. An "open" account with no funds in it does not represent any kind of an asset which could provide support to the petitioner. It is the assets in the account which are critical to eligibility determination, not the existence of the account itself. There is nothing in the regulations which would require any

Medicaid claimant to close any trust or other account as a condition of eligibility. When the worker requested a letter showing that the account was closed as a condition to determining her eligibility, he was requesting information from the petitioner which was not necessary for determination of her eligibility. Her "failure" to provide that information, therefore, should not have been used as a reason to delay her eligibility determination.

The evidence shows the petitioner's financial eligibility for Medicaid should have been determined in her favor in September of 1990. The evidence also shows that beginning in that same month the Medicaid division had a surplus of slots due to an unusual and sizable increase in slots from H.C.F.A. which eliminated the waiting list for several months. But for the actions of the Department denying her application for a needless "verification", the petitioner would have certainly received a "slot" for waivered services beginning in October of 1990. The petitioner must not be penalized for the Department's mistake. The only way to remedy this mistake is to correct her eligibility back to October 1, 1990.[1]

The petitioner has covered most of her expenses since October of 1990 through a loan. Ordinarily, Medicaid pays the provider and does not reimburse recipients for expenses. However, the regulations clearly make an exception for reimbursements for expenses paid by persons whose eligibility was initially erroneously determined and later

corrected and reversed. M ɔ 151. There is no impediment, therefore, to repayment of the petitioner's expenses in this matter from October 1, 1990 through August 3, 1991.

FOOTNOTES

[1]That remedy is quite different from finding her retroactively eligible to the date of application after verification was received. That issue is not decided in this opinion.

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